# AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize_____
(NAME OF PHYSICIAN OR HEALTH CARE PROVIDER AUTHORIZED OT USE OR DISCLOSE INFORMATION)

At the request of the undersigned individual, the medical provider designated above is authorized to disclose specified medical records to a representative of Gemini Duplication, Inc. Gemini Duplication, Inc. is authorized by the patient and/or the patient's representative and/or the patient's attorney to receive information pertaining to:

**Patient Name**: Jonathan Shockley _____ **AKA**: _____
**Date of Birth**: 9/27/78 _____ **SSN**: 217-25-7160 _____
**Representing Attorney**: _____

**Health Information Requested** (Check all that apply):

___ Any and all Medical Records
___ Consultation Reports
___ Progress Notes
___ Laboratory, Pathology Reports
___ Radiology/Imaging Reports
___ Actual X-Rays, MRIs, CT Scans
___ Other:

___ For the last ___ years
___ Patient Billing Information
___ Immunization Records
From ____ to ____
From ____ to ____
From ____ to ____
___ Personnel & Wage Records

**Note**: Records may include information related to mental health, alcohol or drug use, and HIV/AIDS. However, treatment records from mental health and alcohol or drug departments and results of HIV tests will not be disclosed unless specifically requested (**Initial all that apply**):

_____ Mental Health _____Alcohol/Drugs _____HIV/AIDS _____Sexually Transmitted Diseases

**Expiration:** This authorization is effective for one year from the date of the signature unless a different date is specified here: _____.

**Revocation:** This authorization may be revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request. A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization. The medical provider shall not condition treatment, payment, enrollment, or eligibility for benefits on the submission of this authorization.

**Note**: Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Jonathan Shockley _____ March 7, 2019
Jonathan Shockley
(Signature of patient, patient representative, or attorney) Date

_____ _____
**(If signed by someone other than patient, indicate relationship)** **Date**

*Required by Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164; pursuant to Evidence Code section 1158*

GEMINI
EDISCOVERY • EVIDENCE • REPORTS

*590 Menlo Drive, Suite 1, Rocklin, CA 95765*
*p. 877-739-7481 f. 877-739-7498*